CHRISTOPHER ROGERS

v.

MAREE LYNETTE WHITAKER

HIGH COURT, AUSTRALIA
MASON CJ, BRENNAN, DAWSON,
TOOHEY, GAUDRON AND McHUGH JJ
[F.C. 92/045]
19 NOVEMBER 1992

TORT: Negligence - Duty of care - Standard of care - Foresight - Rights - Duty of disclosure.

The appellant is an ophthalmic surgeon who performed surgery on the respondent's right eye. This appeal revolves around an allegation of negligence resulting in blindness in both the eyes of the respondent. The symptom is known as sympathetic ophthalmia. During the trial evidence was submitted to the effect that the risk of getting sympathetic ophthalmia is very slight. The Court of Appeal held that it is the duty of a doctor to exercise reasonable care and skill in the provision of professional advice and treatment, the standard of care being that of the ordinary skilled person exercising and professing to have that special skill.

Held:
This standard of skill is however not determined solely or primarily by the practice of the relevant profession or trade. Due consideration must also be given to the fact that a person is entitled to make his own decisions about his life. As regards the duty of disclosure of facts and risks involved, a patient is entitled to know what risks are involved in undergoing or foregoing the surgery or other treatment. Whether or not a doctor is in breach of the requisite standard of care varies according to diagnosis, treatment or the provision of information or advice. It is the duty of a doctor to warn the patient of any material risk, particularly if the patient, if warned of the risk, considers it to be significant. In the present case, the risk is material. A risk which entails a duty to warn is one which is foreseeable and real but not one which is "far-fetched or fanciful".

[Appeal dismissed]

Cases referred to:
Sidaway v. Governors of Bethlem Royal Hospital [1985] AC 871, p. 893. p. 881 ***(refd)***
Gover v. South Australia [1985] 39 SASR 543 p. 551 ***(refd)***
Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582, pp. 586 - 587 ***(refd)***
Whitehouse v. Jordan [1981] 1 WLR 246, p. 258 ***(refd)***
Maynard v. West Midlands RHA [1984] 1 WLR 634, p. 638 ***(refd)***
Hills v. Potter [1984] 1 WLR 641 ***(refd)***
Blyth v. Bloomsbury Health Authority ***(refd)***
Gold v. Haringey Health Authority [1987] 3 WLR 649 ***(refd)***
Mutual Life Ltd. v. Evatt [1971] AC 793 ***(refd)***
Saif Ali v. Sydney Mitchell & Co. [1980] AC 198 ***(refd)***
Hunter v. Hanley [1955] SLT 213 ***(refd)***
Canterbury v. Spence [1972] 464 F. 2d 772, p. 781 ***(refd)***
Battersby v. Tottman [1985] 37 SASR 524 ***(refd)***
Reibl v. Hughes [1980] 114 DLR (3d) 1 ***(refd)***
Cook v. Cook [1986] 162 CLR 376 ***(refd)***
Papatonakis v. Australian Telecommunications Commission [1985] 156 CLR 7 ***(refd)***
Weber v. Land Agents Board [1986] 40 SASR 312 ***(refd)***
Lewis v. Tressider Andrews Associates Pty. Ltd. [1987] 2 Qd R. 533 ***(refd)***
Florida Hotels Pty. Ltd. v. Mayo [1965] 113 CLR 588 ***(refd)***
Albrighton v. Royal Prince Alfred Hospital [1980] 2 NSWLR 542 ***(refd)***
E v. Australian Red Cross [1991] 99 ALR 601 ***(refd)***
F v. R [1983] 33 SASR 189, p. 190 ***(refd)***
Ellis v. Wallsend District Hospital ***(refd)***
Chatterton v. Gerson [1981] QB 432 ***(refd)***
Lanphier v. Phipos [1838] 8 Car & P 475 ***(refd)***
Wyong Shire Council v. Shirt [1980] 146 CLR 40, p. 47 ***(refd)***
Gala v. Preston [1991] 172 CLR 243, p. 253 ***(refd)***

Other sources referred to:
The Law of Torts, Fleming, 7th Edn., p. 110

For the appellant - Blake Dawson Waldron
For the respondent - Henry Davis York

JUDGMENT

Mason CJ, Brennan, Dawson, Toohey & McHugh JJ:
The appellant, Christopher Rogers, is an ophthalmic surgeon. The respondent, Maree Lynette Whitaker, was a patient of the appellant who became almost totally blind after he had conducted surgery upon her right eye. The respondent commenced proceedings against the appellant for negligence in the Supreme Court of New South Wales and obtained judgment in the amount of $808,564.38. After an unsuccessful appeal to the Court of Appeal of New South Wales [1991] 23 NSWLR 600, the appellant now appeals to this Court.

There is no question that the appellant conducted the operation with the required skill and care. The basis upon which the trial Judge, Campbell J., found the appellant liable was that he had failed to warn the respondent that, as a result of surgery on her right eye, she might develop a condition known as sympathetic ophthalmia in her left eye. The development of this condition after the operation and the consequent loss of sight in her left eye were particularly devastating for the respondent as she had been almost totally blind in her right eye since a penetrating injury to it at the age of nine. Despite this early misfortune, she had continued to lead a substantially normal life: completing her schooling, entering the workforce, marrying and raising a family. In 1983, nearly forty years after the initial injury to her right eye and in preparation for a return to the paid workforce after a three year period during which she had looked after her injured son, the respondent decided to have an eye examination. Her general practitioner referred her to Dr. Cohen, an ophthalmic surgeon, who prescribed reading glasses and referred her to the appellant for possible surgery on her right eye.

The respondent did not follow up the referral until 22 May 1984 when she was examined by the appellant for the first time. The appellant advised her that an operation on the right eye would not only improve its appearance, by removing scar tissue, but would probably restore significant sight to that eye. At a second consultation approximately three weeks later, the respondent agreed to submit to surgery. The surgical procedure was carried out on 1 August 1984. After the operation, it appeared that there had been no improvement in the right eye but, more importantly, the respondent developed inflammation in the left eye as an element of sympathetic ophthalmia. Evidence at the trial was that this condition occurred once in approximately 14,000 such procedures, although there was also evidence that the chance of occurrence was slightly greater when, as here, there had been an earlier penetrating injury to the eye operated upon. The condition does not always lead to loss of vision but, in this case, the respondent ultimately lost all sight in the left eye.

As the sight in her right eye had not been restored in any degree by the surgery, the respondent was thus almost totally blind.

In the proceedings commenced by the respondent, numerous heads of negligence were alleged. Campbell J. rejected all save the allegation that the appellant's failure to warn of the risk of sympathetic ophthalmia was negligent and resulted in the respondent's condition. While his Honour was not satisfied that proper medical practice required that the appellant warn the respondent of the risk of sympathetic ophthalmia if she expressed no desire for information, he concluded that a warning was necessary in the light of her desire for such relevant information. The Court of Appeal (Mahoney, Priestley and Handley JJ.A.) dismissed all grounds of the appellant's appeal from the judgment of $808,564.38 on both liability and damages; the Court also dismissed a cross-appeal by the respondent on the question of general damages. The respondent does not pursue the latter issue in this Court but the appellant has appealed on the questions of breach of duty and causation.

Breach of duty

Neither before the Court of Appeal nor before this Court was there any dispute as to the existence of a duty of care on the part of the appellant to the respondent. The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment" (*Sidaway v. Governors of Bethlem Royal Hospital* [1985] AC 871, per Lord Diplock at p. 893); it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case (*Gover v. South Australia* [1985] 39 SASR 543 p. 551). It is of course necessary to give content to the duty in the given case.

The standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill (*Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582, p. 586; see also *Whitehouse v. Jordan* [1981] 1 WLR 246, per Lord Edmund-Davies at p. 258 and *Maynard v. West Midlands RHA* [1984] 1 WLR 634, per Lord Scarman at p. 638), in this case the skill of an ophthalmic surgeon specializing in corneal and anterior segment surgery. As we have stated, the failure of the appellant to observe

this standard, which the respondent successfully alleged before the primary Judge, consisted of the appellant's failure to acquaint the respondent with the danger of sympathetic ophthalmia as a possible result of the surgical procedure to be carried out. The appellant's evidence was that "sympathetic ophthalmia was not something that came to my mind to mention to her".

The principal issue in this case relates to the scope and content of the appellant's duty of care: did the appellant's failure to advise and warn the respondent of the risks inherent in the operation constitute a breach of this duty? The appellant argues that this issue should be resolved by application of the so-called *Bolam* principle, derived from the direction given by McNair J. to the jury in the case of *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582. In *Sidaway v. Governors of Bethlem Royal Hospital* [1985] AC at p. 881, Lord Scarman stated the *Bolam* principle in these terms:

> The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment.

Before the primary Judge there was evidence from a body of reputable medical practitioners that, in the circumstances of the present case, they would not have warned the respondent of the danger of sympathetic ophthalmia; there was also, however, evidence from similarly reputable medical practitioners that they would have given such a warning. The respondent, for her part, argues that the *Bolam* principle should not be applied if it entails Courts deferring to the medical experts in medical negligence cases and that, in any event, the primary Judge was correct in the circumstances of this case in not deferring to the views of those medical practitioners who gave evidence that they would not have warned the respondent.

The *Bolam* principle has invariably been applied in English Courts (*Whitehouse v. Jordan; Maynard v. West Midlands RHA; Hills v. Potter* [1984] 1 WLR 641; *Sidaway; Blyth v. Bloomsbury Health Authority*, unreported, Court of Appeal, February 5 1987; *Gold v. Haringey Health Authority* [1987] 3 WLR 649). In decisions outside the field of medical negligence, there are also statements consistent with an application of the *Bolam* principle (*Mutual Life Ltd. v. Evatt* [1971] AC 793, at p. 804; *Saif Ali v. Sydney Mitchell & Co.* [1980] AC 198, at pp. 218, 220). At its basis lies the recognition that, in matters involving medical expertise, there is ample scope for genuine difference of opinion and that a practitioner is not negligent merely because his or her conclusion or procedure differs from that of other practitioners (see *Hunter v. Hanley* [1955] SLT 213, per Lord President Clyde at p. 217); a finding of negligence requires a finding that the defendant failed to exercise the ordinary skill of a doctor practising in the relevant field. Thus in, *Whitehouse v. Jordan* [1981] 1 WLR 246, judgment entered for the plaintiff was set aside because, in the face of expert evidence that the defendant's efforts in delivering the plaintiff were competent, there was insufficient evidence upon which the trial Judge could hold that there was negligence. Similarly, in *Maynard v. West Midlands RHA* [1984] 1 WLR 634, judgment entered for the plaintiff was set aside on the ground that it was not sufficient to establish negligence on the part of the defendant to show that there was a body of competent professional opinion that considered the decision to perform a particular operation was wrong when there was also a body of equally competent professional opinion which supported that decision as reasonable.

In *Sidaway,* the House of Lords considered whether the *Bolam* principle should be applied in cases of alleged negligence in providing information and advice relevant to medical treatment. The plaintiff underwent an operation on her spine designed to relieve her recurrent neck, shoulder and arm pain. The operation carried an inherent, material risk, assessed at between 1 and 2 per cent, of damage to the spinal column and nerve roots. The risk eventuated and the plaintiff was severely disabled. She sued in negligence, alleging that the surgeon had failed to disclose or explain to her the risks involved in the operation. As the speeches in the House of Lords make clear, the action was destined to fail because there was no reliable evidence in support of the plaintiff's central pleading that the surgeon had given no advice or warning. Nevertheless, the majority of the Court (Lord Scarman dissenting) held

that the question whether an omission to warn a patient of inherent risks of proposed treatment constituted a breach of a doctor's duty of care was to be determined by applying the *Bolam* principle. However, the members of the majority took different views of the *Bolam* principle. Lord Diplock gave the principle a wide application; he concluded that, as a decision as to which risks the plaintiff should be warned of was as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, expert evidence on this matter should be treated in just the same way as expert evidence on appropriate medical treatment ([1985] AC at p. 895). Lord Bridge of Harwich (with whom Lord Keith of Kinkel agreed) accepted that the issue was "to be decided primarily on the basis of expert medical evidence, applying the *Bolam* test" *(ibid.,* at p. 900) but concluded that, irrespective of the existence of a responsible body of medical opinion which approved of non-disclosure in a particular case, a trial Judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical practitioner would fail to make it. Lord Templeman appeared even less inclined to allow medical opinion to determine this issue. He stated (*ibid.,* at p. 903):

> (T)he Court must decide whether the information afforded to the patient was sufficient to alert the patient to the possibility of serious harm of the kind in fact suffered.

However, at the same time, his Lordship gave quite substantial scope to a doctor to decide that providing all available information to a patient would be inconsistent with the doctor's obligation to have regard to the patient's best interests (*ibid.,* at p. 904). This is the doctor's so-called therapeutic privilege, an opportunity afforded to the doctor to prove that he or she reasonably believed that disclosure of a risk would prove damaging to a patient (see *Canterbury v. Spence* [1972] 464 F. 2d 772, at p. 789; *Sidaway* [1985] AC, per Lord Scarman at p. 889. See also *Battersby v. Tottman* [1985] 37 SASR 524, at pp. 527 - 528, 534 - 535).

In dissent, Lord Scarman refused to apply the *Bolam* principle to cases involving the provision of advice or information. His Lordship stated [1985] AC, at p. 876:

> In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the Court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes.

His Lordship referred to American authorities, such as the decision of the United States Court of Appeals, District of Columbia Circuit, in *Canterbury v. Spence* [1972] 464 F 2d 772, and to the decision of the Supreme Court of Canada in *Reibl v. Hughes* [1980] 114 DLR (3d) 1., which held that the "duty to warn" arises from the patient's right to know of material risks, a right which in turn arises from the patient's right to decide for himself or herself whether or not to submit to the medical treatment proposed.

One consequence of the application of the *Bolam* principle to cases involving the provision of advice or information is that, even if a patient asks a direct question about the possible risks or complications, the making of that inquiry would logically be of little or no significance; medical opinion determines whether the risk should or should not be disclosed and the express desire of a particular patient for information or advice does not alter that opinion or the legal significance of that opinion. The fact that the various majority opinions in *Sidaway* [1985] AC at pp. 895, 898, 902 - 903, for example, suggest that, over and above the opinion of a respectable body of medical practitioners, the questions of a patient should truthfully be answered (subject to the therapeutic privilege) indicates a shortcoming in the *Bolam* approach. The existence of the shortcoming suggests that an acceptable approach in point of principle should recognize and attach significance to the relevance of a patient's questions. Even if a Court were satisfied that a reasonable person in the patient's position would be unlikely to attach significance to a particular risk, the fact that the patient asked questions revealing concern about the risk would make the doctor aware that **this patient** did in fact attach significance to the risk.

Subject to the therapeutic privilege, the question would therefore require a truthful answer.

In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill (*Cook v. Cook* [1986] 162 CLR 376 at pp. 383 - 384; *Papatonakis v. Australian Telecommunications Commission* [1986] 156 CLR 7, at p. 36; *Weber v. Land Agents Board* [1986] 40 SASR 312, at p. 316; *Lewis v. Tressider Andrews Associates Pty. Ltd.* [1987] 2 Qd R. 533, at p. 542). But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade (see, for example, *Florida Hotels Pty. Ltd. v. Mayo* [1965] 113 CLR 588, at pp. 593, 601). Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the *Bolam* principle has not always been applied (see *Albrighton v. Royal Prince Alfred Hospital* [1980] 2 NSWLR 542, at pp. 562-563 (Case of medical treatment). See also *E v. Australian Red Cross* [1991] 99 ALR 601, at p. 650). Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the *Bolam* principle has been discarded and, instead, the Courts have adopted *Albrighton v. Royal Prince Hospital* [1980] 2 NSWLR, at pp. 562 - 563; *F. v. R.* [1983] 33 SASR 189, at pp. 196, 200, 202, 205; *Battersby v. Tottman* [1985] 37 SASR, at pp. 527, 534, 539 - 540; *E. v. Australian Red Cross* [1991] 99 ALR, at pp. 648 - 650 the principle that, while evidence of acceptable medical practice is a useful guide for the Courts, it is for the Courts to adjudicate on what is the appropriate standard of care after giving weight to "the paramount consideration that a person is entitled to make his own decisions about his life (*F. v. R.* [1983] 33 SASR, at p. 193).

In *F v. R.* [1983] 33 SASR 189, which was decided by the Full Court of the Supreme Court of South Australia two years before *Sidaway* in the House of Lords, a woman who had become pregnant after an unsuccessful tubal ligation brought an action in negligence alleging failure by the medical practitioner to warn her of the failure rate of the procedure. The failure rate was assessed at less than 1 per cent for that particular form of sterilization. The Court refused to apply the *Bolam* principle. King CJ said (*ibid.*, at p. 194):

> The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the Court and the duty of deciding it cannot be delegated to any profession or group in the community.

King CJ considered *ibid.*, at pp. 192 - 193 that the amount of information or advice which a careful and responsible doctor would disclose depended upon a complex of factors: the nature of the matter to be disclosed; the nature of the treatment; the desire of the patient for information; the temperament and health of the patient; and the general surrounding circumstances. His Honour agreed with (*ibid.*, at pp. 193 - 194) the following passage from the judgment of the Supreme Court of Canada in *Reibl v. Hughes* [1980] 114 DLR (3d), at p. 13:

> To allow expert medical evidence to determine what risks are material, and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question that is to be concluded on the basis of the expert medical evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment.

The approach adopted by King CJ is similar to that subsequently take by Lord Scarman in *Sidaway* and has been followed in subsequent cases *Battersby v. Tottman; Gover v. South Australia* [1985] 39 SASR, at pp. 551 - 552; *Ellis v. Wallsend District Hospital*, unreported Supreme Court of New South Wales, 16 September 1988; *E. v. Australian Red Cross* [1991] 99 ALR, at pp. 649 - 650. In our view, it is correct.

Acceptance of this approach does not entail an artificial division or itemization of specific, individual duties, carved out of the overall duty of care. The duty of a medical practitioner to exercise reasonable care and skill in the provi-

sion of professional advice and treatment is a single comprehensive duty. However, the factors according to which a Court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice; the different cases raise varying difficulties which require consideration of different factors *F. v. R.* [1983] 33 SASR, at p. 191. Examination of the nature of a doctor-patient relationship compels this conclusion. There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient.

In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended *Chatterton v. Gerson* [1981] QB 432, at p. 443. But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. Because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession. *Whether* a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; *whether* the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices. Except in those cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in disclosing the information, including the risks attending the proposed treatment (See **Fleming, The Law of Torts,** 7th ed (1987), p. 110. Rather, the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patient's apprehended capacity to understand that information.

In this context, nothing is to be gained by reiterating the expressions used in American authorities, such as "the patient's right of self-determination" (see, for example, *Canterbury v. Spence* [1972] 464 F. 2d, at p. 784) or even the oft-used and somewhat amorphous phrase "informed consent". The right of self-determination is an expression which is, perhaps, suitable to cases where the issue is whether a person has agreed to the general surgical procedure or treatment, but is of little assistance in the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure. Likewise, the phrase "informed consent" is apt to mislead as it suggests a test of the validity of a patient's consent (*Reibl v. Hughes* [1980] 114 DLR (3d), at p. 11). Moreover, consent is relevant to actions framed in trespass, not in negligence. Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only found an action in negligence and not in trespass; the consent necessary to negative the offence of battery is satisfied by the patient being advised in broad terms of the nature of the procedure to be performed (*Chatterton v. Gerson* [1981] QB, at p. 443). In *Reibl v. Hughes* the Supreme Court of Canada was cautious in its of use the term "informed consent" ([1980] 114 DLR (3d), at pp. 8 - 11).

We agree that the factors referred to in *F. v. R.* by King CJ [1983] 33 SASR, at pp. 192 - 193 must all be considered by a medical practitioner in deciding whether to disclose or advise of some risk in a proposed procedure. The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege.

The appellant in this case was treating and advising a woman who was almost totally blind in one eye. As with all surgical procedures, the operation recommended by the appellant to the respondent involved various risks, such as retinal detachment and haemorrhage infection, both of which are more common than sympathetic ophthalmia, but sympathetic ophthalmia was the only danger whereby both eyes might be rendered sightless. Experts for both parties described it as a devastating disability, the appellant acknowledging that, except for death under anaesthetic, it was the worst possible outcome for the respondent. According to the findings of the trial Judge, the respondent "incessantly" questioned the appellant as to amongst other things, possible complications. She was, to the appellant's knowledge, keenly interested in the outcome of the suggested procedure, including the danger of unintended or accidental interference with her "good", left eye. On the day before the operation, the respondent asked the appellant whether something could be put over her good eye to ensure that nothing happened to it; an entry was made in the hospital notes to the effect that she was apprehensive that the wrong eye would be operated on. She did not, however, ask a specific question as to whether the operation on her right eye could affect her left eye.

The evidence established that there was a body of opinion in the medical profession at the time which considered that an inquiry should only have elicited a reply dealing with sympathetic ophthalmia if specifically directed to the possibility of the left eye being affected by the operation on the right eye. While the opinion that the respondent should have been told of the dangers of sympathetic ophthalmia only if she had been sufficiently learned to ask the precise question seems curious, it is unnecessary for us to examine it further, save to say that it demonstrates vividly the dangers of applying the *Bolam* principle in the area of advice and information. The respondent may not have asked the right question, yet she made clear her great concern that no injury should befall her one good eye. The trial Judge was not satisfied that, if the respondent had expressed no desire for information, proper practice required that the respondent be warned of the relevant risk. But it could be argued, within the terms of the relevant principle as we have stated it, that the risk was material, in the sense that a reasonable person in the patient's position would be likely to attach significance to the risk, and thus required a warning. It would be reasonable for a person with one good eye to be concerned about the possibility of injury to it from a procedure which was elective. However, the respondent did not challenge on appeal that particular finding.

For these reasons, we would reject the appellant's argument on the issue of breach of duty.

Causation

Although the appellant's notice of appeal challenges the confirmation by the Court of Appeal of the trial Judge's finding that the respondent would not have undergone the surgery had she been advised of the risk of sympathetic ophthalmia, Counsel for the appellant made no submissions in support of it. There is, therefore, no occasion to deal with this ground of appeal.

For the foregoing reasons, we would dismiss the appeal.

Gaudron J:

The facts and the issues are set out in the joint judgment of Mason CJ, Brennan, Dawson, Toohey and McHugh JJ. and I need not repeat them. Save for the comments which follow, I agree with the reasons set out in that judgment and I agree with their Honours' conclusion that the appeal should be dismissed.

There is no difficulty in analysing the duty of care of medical practitioners on the basis of a "single comprehensive duty" *(Sidaway v. Governors of Bethlem Royal Hospital* [1985] AC 871 per Lord Diplock at p. 893) covering diagnosis, treatment and the provision of information and advice, provided that it is stated in terms of sufficient generality. Thus, the general duty may be stated as a duty to exercise reasonable professional skill and judgment. But the difficulty with that approach is that a statement of that kind says practically nothing - certainly, nothing worthwhile as to the content of the duty. And it fails to take account of the considerable conceptual and practical differences between diagnosis and treatment, on the one hand, and the provision of information and advice, on the other.

The duty involved in diagnosis and treatment is to exercise the ordinary skill of a doctor practising in the area concerned (*Lanphier v. Phipos* [1838] 8 Car & P 475, per Tindal CJ at p. 479 (173 ER 581 at p. 583); *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582, per McNair J. at pp. 586 - 587; *F. v. R.* [1983] 33 SASR 189 per King CJ at p. 190). To ascertain the precise content of this duty in any particular case it is necessary to determine, amongst other issues, what, in the circumstances, constitutes reasonable care and what constitutes ordinary skill in the relevant area of medical practice. These are issues which necessarily direct attention to the practice or practices of medical practitioners. And, of course, the current state of medical knowledge will often be relevant in determining the nature of the risk which is said to attract the precise duty in question, including the foreseeability of that risk.

The matters to which reference has been made indicate that the evidence of medical practitioners is of very considerable significance in cases where negligence is alleged in diagnosis or treatment. However, even in cases of that kind, the nature of particular risks and their foreseeability are not matters exclusively within the province of medical knowledge or expertise. Indeed, and notwithstanding that these questions arise in a medical context, they are often matters of simple commonsense. And, at least in some situations, questions as to the reasonableness of particular precautionary measures are also matters of commonsense. Accordingly, even in the area of diagnosis and treatment there is, in my view, no legal basis for limiting liability in terms of the rule known as "the *Bolam* test" (This test derives from the charge to the injury by McNair J. in *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR at p. 587) which is to the effect that a doctor is not guilty of negligence if he or she acts in accordance with a practice accepted as proper by a responsible body of doctors skilled in the relevant field of practice. That is not to deny that, having regard to the onus of proof, "the *Bolam* test" may be a convenient statement of the approach dictated by the state of the evidence in some cases. As such, it may have some utility as a rule-of-thumb in some jury cases, but it can serve no other useful function.

Diagnosis and treatment are but particular duties which arise in the doctor-patient relationship. That relationship also gives rise to a duty to provide information and advice. That duty takes its precise content, in terms of the nature and detail of the information to be provided, from the needs, concerns and circumstances of the patient. A patient may have special needs or concerns which, if known to the doctor, will indicate that special or additional information is required. In a case of that kind, the information to be provided will depend on the individual patient concerned. In other cases, where, for example, no specific enquiry is made, the duty is to provide the information that would reasonably be required by a person in the position of the patient.

Whether the position is considered from the perspective of the individual patient or from that of the hypothetical prudent patient and unless there is some medical emergency or something special about the circumstances of the patient, there is simply no occasion to consider the practice or practices of medical practitioners in determining what information should be supplied. However, there is some scope for a consideration of those practices where the question is whether, by reason of emergency or the special circumstances of the patient, there is no immediate duty or its content is different from that which would ordinarily be the case.

Leaving aside cases involving an emergency or circumstances which are special to the patient, the duty of disclosure which arises out of the doctor-patient relationship extends, at the very least (In *Canterbury v. Spence* [1972] 464 F. 2d 772, at p. 781, other matters identified as being within the duty of disclosure were the duty to alert the patient to bodily abnormality, the failure of the patient's ailment to respond to the doctor's ministrations, limitations to be observed for his or her welfare, precautionary therapy for the future and the need for or desirability of alternative treatment promising greater benefit.), to information that is relevant to a decision or course of action which, if taken or pursued, entails a risk of the kind that would, in other cases, found a duty to warn. A risk is one of that kind if it is real and foreseeable, but not if it is "far-fetched or fanciful" (*Wyong Shire Council v. Shirt* [1980] 146 CLR 40, per Mason J. at p. 47. See also

Gala v. Preston [1991] 172 CLR 243, at p. 253). Certainly, the duty to warn extends to risks of that kind involved in the treatment or procedures proposed.

Again leaving aside cases involving a medical emergency or a situation where the circumstances of the individual require special consideration, I see no basis for treating the doctor's duty to warn of risks (whether involved in the treatment or procedures proposed or otherwise attending the patient's condition or circumstances) as different in nature or degree from any other duty to warn of real and foreseeable risks. And as at present advised, I see no basis for any exception or "therapeutic privilege" which is not based in medical emergency or in consideration of the patient's ability to receive, understand or properly evaluate the significance of the information that would ordinarily be required with respect to his or her condition or the treatment proposed.

The appeal should be dismissed.

WEBB

v.

EMO AIR CARGO (UK) LIMITED

HOUSE OF LORDS
LORD KEITH OF KINKEL, LORD GRIFFITHS, LORD BROWNE-WILKINSON, LORD MUSTILL, LORD SLYNN OF HADLEY
26 NOVEMBER 1992

LABOUR LAW: Sex discrimination - Sections 1, 2, 5 and 6, Sex Discrimination Act 1975 - Direct or indirect discrimination - Article 2(1) Directive 76/207 - Council of European Communities.

The appellant was employed by the respondents as a clerk to replace another clerk who was pregnant. After commencing work she found out that she herself was pregnant. Upon discovering this, the respondent dismissed her. The Tribunal found that the respondent treated male and female employees alike and both were given full pay on sick leave without a specific time limit. Also the Tribunal decided that had the appellant revealed that she was pregnant at her initial interview she would not have been offered the job. It dismissed the appellant's claim that her dismissal constituted direct discrimination on the ground of sex, or alternatively indirect discrimination, contrary to the Sex Discrimination Act, 1975. The appellant's appeal to the Employment Appeal Tribunal and the Court of Appeal were dismissed. Leave was granted to appeal to the House of Lords.

Held:

[1] The precise reason for the unavailability for work is not relevant under s. 5(3) of the 1975 Act. It is also not relevant that the reason is a condition which affects only women, or for that matter only men. This view derives support from s. 2(2) of the Act. Therefore the appellants dismissal did not constitute direct unlawful discrimination.

[2] Earlier European Court decisions did not indicate whether regard should be taken of a situation where an employer refuses to engage a woman for her unavailability for the job and not for her pregnancy. Hence referral should be made to the European Court the following question for determination: